

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Cardiac Output and Function After Revascularization

TO THE EDITOR: I wish to express our appreciation of the thoughtful editorial by Califf and Rosati¹ in the October issue. It helps to place our paper² in the same issue in appropriate perspective.

I would, however, take issue with one point in their assessment of our community findings in relation to coronary artery bypass grafting. First, there is growing evidence that there is only a poor correlation between ejection fraction at rest and during strenuous exercise in patients with coronary heart disease. Second, we have follow-up invasive studies on nearly 50 patients in whom we have measured cardiac output by the direct Fick principle at graded levels of upright exercise up to symptom-limited exertion. Substantial changes in cardiac output, and therefore function, are observed in proportion to the adequacy of revascularization.³ Hence, I need to caution about inferring that "the difference in survival is probably due to the better left ventricular function in the surgical patients [preoperative] rather than to the operation itself." The first reports of these findings appeared in the *British Heart Journal*⁴ and in *Circulation*⁵ which prompted us to seek and to obtain NHLBI funding for a more extensive study which is nearing completion.

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2. Bruce RA, Hossack KF, Belanger L, et al: A computer terminal program to evaluate cardiovascular functional limits and estimate coronary event risks (Health Care Delivery). West J Med 1981 Oct; 135:342-350
3. Hossack KF, Bruce RA, Kusumi F, et al: Increased maximal cardiac output following bypass surgery. Cardiac Society of Aust & NZ, Mar 1981
4. Gey GO, Rudd T, Bruce RA: Improvement in exertional left ventricular dysfunction after revascularization. Br Heart J 1976 Oct; 38:1102-1104
5. Miller DW, Bruce RA, Dodge HT: Physiologic improvement following coronary artery bypass surgery. Circulation 1978; 57:831-835

The International System of Units (SI)

TO THE EDITOR: In our article on the International System of Units (SI)¹ in the December issue, we stated that Dr. William Barclay heads the Medical and Health Coordinating Group working on SI. Dr. Edward R. Powsner of Ingham Medical Center in Lansing, Michigan, has been elected chairman. In moving ahead with this effort, the group has agreed on the following:

The objective of the Medical and Health Coordinating Group (MHCG) is to provide the framework for working with appropriate individuals and organizations to expedite a uniform system of SI units in the various health sectors. The MHCG will provide guidance for all interested parties who desire to use the international (SI) metric system and to encourage consistent and proper applications of SI throughout the health field.

It will be interesting to observe the directions of the SI movement in the United States.

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1. Bergeson PS, Smith EI: The international system of units (SI) and medicine. West J Med 1981 Dec; 135:526-529

Geriatric Medicine

TO THE EDITOR: This regards the December editorial "The Elderly as Interdependent Persons." Right on! Perhaps partly because of your "physical-psychological-social" triangles 32 years ago, I have developed two nonprofit housing projects for the elderly, assisted in formation of the University of San Francisco's gerontology program and learned about social interdependence in tens of thousands of thorough periodic check-ups. As I read the December issue on Geriatric Medicine, I searched in vain for adequate recognition of such principles as, "the deepest principle of human nature is the craving to be appreciated" (William James), or "the cloistered controls had twice the mortality rate of those encouraged to help each other" (nursing home study) or "the 3 communities with large proportions of centenar-

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ians had active, respected and productive niches for them" (*National Geographic*, 1972, approximately). That is, until your integrating editorial.¹

The most graphic wisdom about geriatric medicine may be in the story of the man told "Your knee is not red, swollen, tender or unstable so it must be your age; after all, you're 103, Fred." "But, Doc, my other knee is also 103, and it don't hurt." The most important thing I learned from biostatistics was "Know your assumptions." You've heard about the statistician who drowned crossing a stream that *averaged* just one foot deep? Age should just alert us to a shift of probabilities. Respect requires individualization.

As the editorial so eloquently stated, "What appears to be needed is to further strengthen community and interpersonal action by the elderly. . . ." Is that not an application of the commandment, "Honor thy father and thy mother . . . that it may go well with thee"?

The chief problem of American elderly persons is *dis-ease* from condescension.

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1. The elderly as interdependent persons (Editorial). *West J Med* 1981 Dec; 135:519

Language of Medical Diagnosis

TO THE EDITOR: Hats off to Dr. Weinberger!^{1,2} He has diagnosed a common condition—perversion of the language of medical diagnosis. This is most often encountered where, despite long-lived symptoms, no evidence of organic disease can be adduced. Reluctant to face foursquare and divulge the absence of organic disease, the physician applies a diagnostic euphemism. This lack of straightforward disclosure as to the nature of his malady leaves the patient to flounder indefinitely in his belief that what he has, no matter how vague and ill-defined, is "real," or "physical." The "kindly" physician has spared him the painful confrontation with the reality that his symptoms are psychogenic or "mental."

The failure to confront and disclose psychogenic symptoms for what they are abets chronicity and abuse in such disorders. It is "pure arrogance" for

a physician to fail to disclose, in clear language, the probable nature of a disease to a comprehending patient.

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2. Bennett RM: Author's reply to fibrositis (Correspondence). *West J Med* 1981 Nov; 135:426

Peptic Ulcer and Scapulocostal Syndrome

TO THE EDITOR: About 20 years ago, I discovered that peptic ulcer (or preulcer) disease may be a cause of the scapulocostal syndrome. This knowledge has helped me save many thousands of dollars for my patients. The scapulocostal syndrome is generally not well known, and peptic ulcer disease apparently has not been reported as one of the causes.

Scapulocostal syndrome on the left side may mimic myocardial infarction or angina pectoris with pain in the shoulder, neck, arm and chest in the fourth and fifth intercostal nerve areas. Women may also complain of breast pain and tenderness.

The scapulocostal syndrome characteristically has a trigger point at the upper medial angle of the scapula and tenderness over the fourth and fifth intercostal nerves on the involved side. There is frequently cervical muscle spasm with secondary headache suggesting tension headaches, greater occipital neuralgia, migraine or even brain tumor.

When the scapulocostal syndrome is secondary to peptic disease, anesthetizing the stomach with the ingestion of 10 to 15 ml of undiluted viscous xylocaine will soon result in considerable to complete relief of the pain, cervical myospasm and the tenderness of the fourth and fifth intercostal nerves and the trigger point. Treatment of the peptic syndrome will result in relief if no other coexisting causes are present. When due to peptic ulcer disease, the scapulocostal syndrome appears to occur more often on the left but may also be on the right or bilateral. Postural problems such as poor shoulder posture or a short leg may also cause the scapulocostal syndrome or may be coexistent causes and should be corrected.

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